GEORGIA DEPARTMENT OF COMMUNITY HEALTH

GEORGIA MEDICAID FEE-FOR-SERVICE
PARENTERAL NUTRITION PRODUCTS PA SUMMARY

Preferred	Non-Preferred
n/a	Kabiven (amino acid, electrolytes, dextrose, lipid for injection) Perikabiven (amino acid, electrolytes, dextrose, lipid for injection)
Nutrilipid (soybean oil fat/lipid emulsion for injection) Omegaven (fish oil fat/lipid emulsion for infusion)*	Clinolipid (soybean oil fat/lipid emulsion for injection) Intralipid (soybean oil fat/lipid emulsion for injection) Smoflipid (fish oil, medium-chain triglycerides, olive oil, soybean oil fat/lipid emulsion for injection)

*preferred but requires PA

LENGTH OF AUTHORIZATION: Up to 1 year

NOTES:

- Omegaven is preferred but requires prior authorization (PA).
- If medication is being administered in a physician's office or clinic, then the medication must be billed through the DCH physician's injectable program and not the outpatient pharmacy program. Information regarding the physician's injectable program can be located at www.mmis.georgia.gov.

PA CRITERIA:

Kabiven and Perikabiven

- Approvable for members 18 years of age or older when oral or enteral nutrition is not possible, insufficient or contraindicated

AND

- Member's parenteral nutrition needs are not able to be obtained through administration of individual products that contain amino acid, dextrose, lipid and/or electrolytes.

Clinolipid and Smoflipid

- For members when oral or enteral nutrition is not possible, insufficient or contraindicated, prescriber must submit a written letter of medical necessity stating the reasons the preferred product, Nutrilipid, is not appropriate for the member.

Intralipid

- Approvable for members when oral or enteral nutrition is not possible, insufficient or contraindicated and member's parenteral nutrition needs require 30% fat/lipid emulsion. Otherwise, prescriber must submit a written letter of medical necessity stating the reasons the preferred product, Nutrilipid, is not appropriate for the member.

Omegaven

- Approvable for members for the treatment of parenteral nutrition-associated cholestasis (PNAC) who have a bilirubin level ≥2 mg/dL and who are expected to require parenteral nutrition for at least 14 days.

EXCEPTIONS:

- Exceptions to these conditions of coverage are considered through the prior authorization process.
- The Prior Authorization process may be initiated by calling **OptumRx at 1-866-525-5827.**

PREFERRED DRUG LIST:

- For online access to the Preferred Drug List (PDL), please go to http://dch.georgia.gov/preferred-drug-lists.

PA and APPEAL PROCESS:

- For online access to the PA process, please go to www.dch.georgia.gov/prior-authorization-process-and-criteria and click on Prior Authorization (PA) Request Process Guide.

QUANTITY LEVEL LIMITATIONS:

- For online access to the current Quantity Level Limits (QLL), please go to www.mmis.georgia.gov/portal, highlight Provider Information and click on Provider Manuals. Scroll to the page with Pharmacy Services and select that manual.